Basic Oregon Plan

Maximum Lifetime Benefit	$1,000,000
	(You Pay)
Annual Deductible	None
Annual Out-of-Pocket Limit	$3,750 Individual / $7,500 Family [1]
PREVENTIVE CARE	
Well Baby Care	$15 co-pay
Routine Physicals	$15 co-pay
Routine Women's Exams	$15 co-pay
Prostate Rectal Exam (PRE)	$15 co-pay
Immunizations	$15 co-pay
PROFESSIONAL SERVICES	
Office and Home Visits	50%
Urgent Care Visits	50%
Surgery	50%
Acupuncture	Not Covered
Chiropractic	
Naturopathic	
MATERNITY CARE	
Practitioner Services	50%
Hospital Stay	50%
HOSPITAL SERVICES	
Inpatient Care	50%
Skilled Nursing Facility Care	50%
OUTPATIENT SERVICES	
Outpatient Hospital/Facility	50%
Outpatient Diagnostic X-Ray and Lab	50%
Specified Imaging (MRI, CT, CAT, PET scans)	50%
Emergency Room Visits	50%
OTHER COVERED SERVICES	
Physical Therapy	50%
Allergy Injections	50%
Ambulance Service ($5,000 annual max)	50%
Durable Medical Equipment/Prosthetics	50%
Home Health, Hospice, and Respite Care	50%
PRESCRIPTION DRUG (Show your ODS ID card to access discounts at participating pharmacies.)	$15 or 50%, whichever is greater for retail or mail order

[1] Prescription drug co-pays and disallowed charges do not apply to the annual out of pocket maximum.

www.odscompanies.com

This plan may be underwritten or administered by ODS Health Plan, Inc.

DEPENDENT ELIGIBILITY

Dependents are lawful spouse, Oregon registered domestic partners and unmarried children to age 23, including children an employee is required to enroll due to a court or administrative order.

LIMITATIONS

* Pre-existing conditions even if they worsen or reoccur.

Note: Your plan's six month pre-existing exclusion period will be shortened one day for each day you had "creditable coverage" under another health plan, provided you do not have a 63 day lapse (or longer) in coverage immediately prior to your enrollment date in our plan, or, if earlier, the first day of the waiting period for such enrollment.

* All medical and surgical admissions must be authorized by ODS.
* Mental illness / chemical dependency (including alcoholism) will be treated the same as other medical conditions except for mental health residential treatment that has a 45-day limit per calendar year.
* When a member has more than one group plan, combined benefits for both group plans will be provided up to, but not exceeding, the maximum plan allowance for all covered services.
* Inpatient rehabilitation benefits are limited to 30 days per condition (prior authorization for up to 60 days for head and spinal cord injuries); outpatient rehabilitation benefits are limited to 30 sessions per condition (prior authorization for up to 60 sessions for head and spinal cord injuries).
* Hospice benefits are limited to 12 days of inpatient care; Respite care is limited to 170 hours.

EXCLUSIONS

* Services provided by the patient or a member of the patient's immediate family.
* Services or supplies which are not medically necessary.
* Services and supplies for reversal of sterilization or infertility.
* Services and supplies for obesity, including complications arising out of such treatment.
* Surgery to alter the refractive character of the eye.
* Dental examinations and treatment, except as specifically listed.
* Acupuncture.
* Massage or massage therapy.
* Services or supplies related to Gender Identity Disorders, for members age nineteen and older.
* Services or supplies related to sex change procedures or sexual dysfunction unless delivered by a mental health provider.
* Medical services or supplies for the treatment of sexual dysfunctions or inadequacies, except when delivered by a mental health provider as defined in this plan.
* Experimental or investigational treatment.
* Chiropractic Services.
* Naturopathic Services.
* Services or supplies available in whole, or in part under any city, county, state, or federal law, except Medicaid.
* Charges above the maximum plan allowance.
* Services or supplies for which an employer is required by law to provide benefits even if you choose not to accept those benefits.
* Instruction programs, including, but not limited to, those to learn to self-administer drugs or nutrition, except as specifically provided for under the outpatient diabetic instruction benefit of this plan.
* Appliances or equipment primarily for comfort, convenience, cosmetics, environmental control, or education.
* Cosmetic / reconstructive services and supplies.
* Services and supplies associated with orthognathic surgery.

www.odscompanies.com

This is a benefit summary only. For a complete description of benefits, limitations and exclusions refer to your member handbook.

This plan may be underwritten or administered by ODS Health Plan, Inc.